Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/9/03.

I. DISPUTE

Whether there should be additional reimbursement for CPT codes 97545 WH CA and 97546 WH CA, for dates of services 9/2/03 – 10/2/03.

II. RATIONALE

The services in dispute were denied as, "F-Reduction according to Fee Guideline."

The Requestor states, in their letter dated 11/25/03, "Our Work Hardening program is CARF certified and due full payment without discount."

Carrier received Medical Dispute on 1/6/04. Their response was received on 1/22/04. Per Commission Rule 133.307 (e)(3), response is considered untimely, therefore, will not be considered.

Medical Fee Guideline, Medicine Ground Rule II (E) states, in part, " Work Hardening programs are interdisciplinary in nature with a capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Work Hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors." (E)(3) states, "Work Hardening requires a minimum of four hours per day except for the first week. A two-hour per day minimum applies during the initial week. Total time spent on the job and in the Work Hardening program shall not exceed 8 hours per day." Documentation, provided by the Requestor, was reviewed. Records indicate that the criteria and time requirements were met. Ground Rule (E)(5) states, "Reimbursement for the Work Hardening program shall be $64.00 per hour."

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
9/2/03	97546 WH CA (x 5 units)	$320.00	$267.01	F	$64.00 per unit	Medical Fee Guideline Medicine Ground Rule II	Required elements have been met. Reimbursement recommended in the amount of $52.99.
9/17/03	97546 WH CA (x 4 units)	$256.00	$179.21	F	$64.00 per unit		Required elements have been met. Reimbursement recommended in the amount of $76.79.
9/18/03	97546 WH CA (x 4 units)	$256.00	$179.21	F	$64.00 per unit		Required elements have been met. Reimbursement recommended in the amount of $76.79.

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
9/22/03	97546 WH CA (x 4 units)	$256.00	$177.41	F	$64.00 per unit		Required elements have been met. Reimbursement recommended in the amount of $78.59.
10/2/03	97545 WH CA (x 2 units)	$128.00	$102.40	F	$64.00 per unit		Required elements have been met. Reimbursement recommended in the amount of $25.60.
10/2/03	97546 WH CA (x 4 units)	$256.00	$12.80	F	$64.00 per unit		Required elements have been met. Reimbursement recommended in the amount of $243.20.
Total							The Requestor is entitled to reimbursement of $553.96.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement in the amount of $553.96. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $553.96 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 28th day of May 2004.

Terri Baayer
Medical Dispute Resolution Officer
Medical Review Division

TB/tb